Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HOUSTON COMMUNITY HOSPITAL
2807 LITTLE YORK
HOUSTON TX 77093

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
COMMERCE & INDUSTRY INSURANCE

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-03-A383-01

MFDR Date Received
AUGUST 25, 2003

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as documented on the Table of Disputed Services: "patient received services"

Amount in Dispute: $8,085.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "This dispute concerns the denial pf payment for services that were not included as part of the compensable injury. Attached is a copy of a Benefit Dispute Agreement signed by all parties agreeing that the claimant's compensable injury does not include the low back. Contrary to the Requestor's statement that preauthorization should have been denied by the filing of the TWCC-21, preauthorization cannot be denied for this reason, since it refers to medical necessity only."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 13367, Austin, TX 78711

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2003	Outpatient Hospital Services	$8,085.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. This request for medical fee dispute resolution was received by the Division on August 25, 2003. Pursuant to

28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 *Texas Register* 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 28, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 1 – Unrelated to the compensable injury.
   - 1 – Our position remains the same: if you disagree with our decision please contract the TWCC Medical Dispute Resolution.
   - E – Entitlement (non-compensable)

Findings

1. The carrier denied the disputed services as unrelated to the compensable injury. According to the TWCC-21 the carrier disputed the compensability and disability to an injury to the low back as not sustained while in the course and scope of employment. The carrier maintained that the employee reported an injury to the right hip and the carrier denied the original injury extended to the low back. On April 16, 2003 a Benefit Dispute Agreement was signed by all parties resolving that the claimant's compensable injury did not include the low back.

   The request for reimbursement is not supported as the services were rendered to a non-compensable body area. Therefore, payment cannot be recommended. As a result, the amount order is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		October 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.